

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05205

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH-
COUNTY Washington MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. LENGTH OF STAY (in this place) 13 days
TOWN Hagerstown
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown
OR TOWN Hagerstown
STREET ADDRESS (If rural, give location) 605 S. Potomac St

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)
HOMER SLATER AHALT

4. DATE OF DEATH (Month) (Day) (Year)
May 18 1951

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married 8. DATE OF BIRTH March 26, 1895 9. AGE last birthday 56-1-22 yrs. If under 1 year Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent of Hagerstown City Park 10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Md. 11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Luther Calvin Ahalt 14. MOTHER'S MAIDEN NAME Maissie Beachley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 214-09-2197 17. INFORMANT AND ADDRESS Mrs. Mag Pauline Ahalt 605 S. Potomac St Hagerstown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 5.5.51

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Sclerosis 9 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1941, 19....., to 5/18/51, 19....., that I last saw the deceased alive on 5/18/51, 19....., and that death occurred at 7:45 A m., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) ADDRESS Hagerstown Md DATE SIGNED 5/19/51

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial May 30, 1951 Rehoboth Cemetery Rehoboth Wash. Co. Md.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS
May 19, 1951 [Signature] Wm J. Eastman Boonsho Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05206

Reg. Dist. No. 302

1. PLACE OF DEATH CITY <u>Washington</u> MARYLAND OR (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (In this place) <u>10 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>Washington Co. Home</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>FRANK RHODES ALTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 11 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2/6/1895</u>
9. AGE last birthday <u>56</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None-Mentally Arrested</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Alter</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Rhodes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Frank Long Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>arterio sclerotic myocardial</u>		
Antecedent cause(s) (b) <u>heart failure grade IV</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>NO</u>		
19a. DATE OF OPERATION <u>NO</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

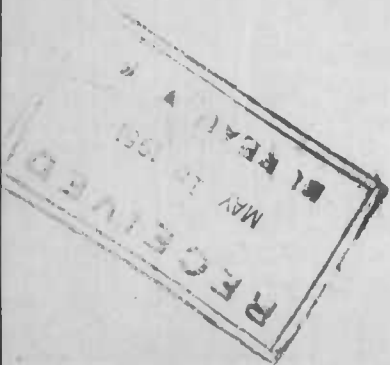
22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE S. Robert Wells MD, Deputy Med. Exam. ADDRESS Hagerstown, Md. DATE SIGNED 5-12-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/14/51</u>	NAME OF CEMETERY OR CREMATORY <u>Salem Reformed Cem.</u>	LOCATION (City, town, or county) (State) <u>Near Gearfoss Md./</u>
DATE REC'D BY LOCAL REG. <u>5/13/1951</u>	REGISTRAR'S SIGNATURE <u>Phasff Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05207

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>816 W. Washington St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Ronald</u> <u>Wayne</u> <u>Andrews</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>5</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 4 1951</u>
9. AGE last birthday <u>yr.</u>		10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert L. Andrews</u>		14. MOTHER'S MAIDEN NAME <u>Thelma L. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Herbert L. Andrews Hagerstown Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Asphyxia due to tracheal obstruction

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Mucous aspiration

(c)

INTERVAL BETWEEN ONSET AND DEATH

7

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hemorrhage, pulmonary, mild
(post resuscitation)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4:52 PM, 1951, to 2:35 A, 1951, that I last saw the deceased alive on 5-5, 1951, and that death occurred at 2:35 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>May 5 1951</u>		<u>Rose Hill Cemetery</u>		<u>Hagerstown</u>		<u>Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>May 5, 1951</u>		<u>Frank J. Powers</u>		<u>CM SUTER & SONS</u>		<u>Hagerstown Maryland</u>			

205041255405

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr Le Van

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. county Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>1134 Potomac Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CAMILLE</u> <u>DeVenus</u> <u>BACHTELL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 7 1951</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan'y 20 1906</u>
9. AGE last birthday <u>45</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Photo Studio</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Bachtell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-8236</u>	
17. INFORMANT AND ADDRESS <u>Mrs Evelyn Altemier, Hagerstown, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of Breast with

INTERVAL BETWEEN ONSET AND DEATH

9 mon.

Antecedent cause(s)

(b) metastasis
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 15, 1951, to May 7, 1951, that I last saw the deceasedalive on May 6, 1951, and that death occurred at 12:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	LOCATION (City, town, or county) <u>Near Clearspring Md.</u>
DATE REC'D BY LOCAL <u>May 7, 1951</u>	REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

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VS. A16

390 849

RECEIVED
MAY 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr Beachley

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>59 Harmans Alley</u>	
3. NAME OF DECEASED (Type or Print) <u>ROBERT</u> (First) <u>LEE</u> (Middle) <u>BARTON</u> (Last)		4. DATE OF DEATH <u>May 31 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Jan 4 1903</u>
9. AGE last birthday <u>48</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Md Pipe & Supply Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harry Barton</u>		14. MOTHER'S MAIDEN NAME <u>Ella Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>314-09-1736</u>	
17. INFORMANT AND ADDRESS <u>Mrs Lucy Barton 59 Harmans Alley</u>			

18. MEDICAL CERTIFICATION Hagerstown Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

502.1

Antecedent cause(s)

80a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 30, 1951 to May 31, 1951, that I last saw the deceasedalive on May 31, 1951, and that death occurred at 14:00 m., from the causes and on the date stated above.SIGNATURE Dr. Beachley

(Degree or title)

ADDRESS Hagerstown, Md.DATE SIGNED June 1, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>June 4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>June 4, 1951</u>	REGISTRAR'S SIGNATURE <u>Dr. Beachley</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970687

RECEIVED
JUN 6 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05210

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>11</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>916 Chestnut Street</u>		STREET ADDRESS (If rural, give location) <u>916 Chestnut Street</u>					
3. NAME OF DECEASED (Type or Print) <u>Annie</u>		(First) <u>L.</u>		(Last) <u>Baxter</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>May 11, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Dec. 29, 1866</u>		9. AGE last birthday <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Jones</u>				14. MOTHER'S MAIDEN NAME <u>Susan Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Grace Slick Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from Jan, 1951, to 11 May, 1951, that I last saw the deceasedalive on 7 May, 1951, and that death occurred at 9:05 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 14, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>		(State)	
DATE REC'D BY LOCAL REG. <u>May 12, 1951</u>		REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>		24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 10 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05211

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendstown</u>	
TOWN <u>Friendstown</u>		TOWN <u>Friendstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 East Maple Street</u>		STREET ADDRESS (If rural, give location) <u>15 East Maple Street</u>	
3. NAME OF DECEASED (First) <u>Eva</u> (Middle) <u>Schall</u> (Last) <u>Bell</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 18 - 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>76-6-18 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Ontario Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Joseph Schall</u>		14. MOTHER'S MAIDEN NAME <u>Lena Weinstein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>219-12-2186</u>	
17. INFORMANT AND ADDRESS <u>Wm. Bell - 15 E. Maple St. Friendstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) MalnutritionAntecedent cause(s) (b) Carcinoma of rectumDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None

INTERVAL BETWEEN ONSET AND DEATH

6 months6 1/2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Friendstown</u>	(CITY OR TOWN) <u>Friendstown</u>	(COUNTY) <u>Washington</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 5 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>From the cause and on the date stated above.</u>	

22. I hereby certify that I attended the deceased from Nov., 1949, to May, 1951, that I last saw the deceasedalive on 5-4, 1951, and that death occurred at 2:50 p.m., from the cause and on the date stated above.SIGNATURE Robert F. Keable MD

(Degree or title)

ADDRESS 132 W. WASHINGTON ST. HAGERSTOWN, MARYLANDDATE SIGNED 5-7-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 9, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>	LOCATION (City, town, or county) <u>Boonsboro Wash. Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>May 8, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert F. Keable</u>	24. FUNERAL DIRECTOR <u>Wm. J. Best & Sons</u>	ADDRESS <u>Boonsboro Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 10 1951

BUREAU V. S.

for Pruitt

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05212

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>	
TOWN <u>HAGERSTOWN</u>		TOWN <u>KEEDYSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASH. CO. HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>MAIN ST.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>KATHRYN</u> (Middle) <u>CAMILLA</u> (Last) <u>BLOOM</u>		(Month) <u>MAY</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT. 17-1889</u>
9. AGE last birthday <u>61-8-4</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>NEAR KEEDYSVILLE MD.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - DEPARTMENT STORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM DENTON WEAVER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE BAYLOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-4994</u>	
17. INFORMANT AND ADDRESS <u>MRS. FRANCES KEPLER - KEEDYSVILLE MD.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Adhesive Peritonitis

INTERVAL BETWEEN ONSET AND DEATH

6 mo.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute Bile Peritonitis10 mo(c) Cholecystitis, chronic, Cholelithiasis 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death:

19a. DATE OF OPERATION

4/22/50, 7/25/50, 8/31/50

19b. MAJOR FINDINGS OF OPERATION

1) Cholelithiasis, 2) Bile Peritonitis, 3) Ext. Bile Fistula

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 21, 1950, to May 21, 1951, that I last saw the deceasedlive on MAY 21, 1951, and that death occurred at 4:40 P. P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Richard V. Hawver M.D. Hagerstown, Md5/22/51

23. BURIAL CREMATION REMOVAL (Specify)

BURIAL

DATE THEREOF

MAY-24-1951

NAME OF CEMETERY OR CREMATORY

MANOR CEMETERY

LOCATION (City, town, or county)

NEAR TILGHMANTON MD.

DATE REC'D BY LOCAL REG.

May 23, 1951

REGISTRAR'S SIGNATURE

Richard V. Hawver

24. FUNERAL DIRECTOR

WM. F. BAST AND SONS BOONSBORO MD.

390646

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED
MAY 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05213

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>539 Guilford Avenue</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Helen</u> (Middle) <u>J.</u> (Last) <u>Bond</u>		(Month) <u>May</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 6, 1875</u>
9. AGE last birthday <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Delaney</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ecton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>William N. Bond Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Diabetic Ketosis</u>		<u>1 Day</u>
Antecedent cause(s) (b) <u>260X</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>61</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>5/3/51</u> , 19....., to <u>5/4/51</u> , 19....., that I last saw the deceased alive on <u>5/4/51</u> , 19....., and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.	
SIGNATURE <u>William N. Bond</u>	DATE SIGNED <u>5/4/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 6, 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>May 5, 1951</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>
ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pa</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (In this place) <u>30 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greencastle Pa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Cor Hospital</u>		STREET ADDRESS (If rural, give location) <u>32 Spring Grove ave</u>	
3. NAME OF DECEASED (Type or Print) <u>COL. JOHN V. BREWER</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>May 1, 1951</u>	(Month) (Day) (Year)
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 26, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Army Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	9. AGE last birthday <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Chambersburg Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William V Brewer</u>		14. MOTHER'S MAIDEN NAME <u>Isabella W Rowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Walter John Brewer Chambersburg Pa 6</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Retropitoneal hemorrhage</u>			<u>2 hrs.</u>
Antecedent cause(s) (b) <u>Liver abscess - type undetermined</u>			<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>no</u>		PLACE (Home, farm, factory, street, office bldg, etc.) INJURY <u>none</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>51</u> , to <u>May 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 1, 1951</u> , and that death occurred at <u>5:30</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Walter J. Brewer</u>		DATE SIGNED <u>5/3/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>May 3, 1951</u>		24. FUNERAL DIRECTOR <u>A.E. Munnich</u>	
REGISTRAR'S SIGNATURE <u>Charles H. Towere</u>		ADDRESS <u>Greencastle Pa</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290916

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05215 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>325 So. Mulberry St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>325 Mulberry</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>GREGORY</u> (Middle) <u>BROOKS</u> (Last)		4. DATE OF DEATH <u>May 24 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar 23 1873</u>
9. AGE last birthday <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood Worker</u>	
11. BIRTHPLACE (State or foreign country) <u>Reisterstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edgar S. Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Barbara E. Hartman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>817-12-2045</u>	
17. INFORMANT AND ADDRESS <u>Mrs Hattie Brooks</u>		18. MEDICAL CERTIFICATION <u>Hagerstown Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

20 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Atherosclerotic heart disease2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1948, to 24 May, 1951, that I last saw the deceasedalive on 20 May, 1951, and that death occurred at 8:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	LOCATION (City, town, or county) <u>Pikesville, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 22/1951</u>	REGISTRAR'S SIGNATURE <u>Dr. H. H. Hocklander</u>	24. FUNERAL DIRECTOR ADDRESS <u>Andrew K. Coffman Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 201

05216

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Md.</u> LENGTH OF STAY (in this place) <u>65 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport Md. RFD #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium 154 N Artizan St.</u>		STREET ADDRESS (If rural, give location) <u>Williamsport Md. RFD #2</u>	
3. NAME OF DECEASED (First) <u>Eva</u> (Middle) <u>Gertrude</u> (Last) <u>Buchanan</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 30 1885</u>
9. AGE last birthday <u>65</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Williamsport Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Henry Ditlow</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Norris</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>John Buchanan RFD #2 Williamsport Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Myocarditis Chronic

6 years

Antecedent cause(s)

(b) None Known

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1945, 19....., to May 26, 1951, that I last saw the deceased alive on May 26, 1951, and that death occurred at 10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURN, CREMATION, EMBALM (Specify)	DATE THEREOF <u>May 22 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Wiverview Cemetery</u>	LOCATION (City, town, or county) <u>Williamsport Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>	24. FUNERAL DIRECTOR <u>Albert L. Leaf</u>	ADDRESS <u>Williamsport Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1964
BUREAU V. S.

05217

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Big Springs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Big Spring, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #1</u>		STREET ADDRESS <u>Route #1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>NANNIE</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>CLAGGETT</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>2</u> (Year) <u>1951</u>
8. DATE OF BIRTH <u>Oct 16 1862</u>	9. AGE last birthday <u>88</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Big Springs Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Samuel Claggett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Shupp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Richard Clopper Big Springs Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral embolismAntecedent cause(s) (b) 420.1Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 94aINTERVAL BETWEEN ONSET AND DEATH
DayII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐
(STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5/1/51, 19....., to 5/2/51, 19....., that I last saw the deceasedalive on 5/2/51, 19....., and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/5/51</u>	<u>Clspg. Mennonite cemetery</u>	<u>Clear springs Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 4, 1951</u>	<u>Joseph W. Murray</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUG 9 1951
BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05218

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp. Hagerstown, Md.</u>		STREET ADDRESS (If rural, give location) <u>1001 Hamilton Blvd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bessie</u>	(Middle) <u>Catherine</u>	(Last) <u>Corderman</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 26, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Big Springs, Maryland</u>
13. FATHER'S NAME <u>William Eader</u>		14. MOTHER'S MAIDEN NAME <u>Susan Angle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>John E. Corderman Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardiovascular Disease

Antecedent cause(s)

(b) Diabetes Mellitus

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Atony of colon

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

10 years8 years6 years3-18-513 days

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 21, 1923, to May 3, 1951, that I last saw the deceasedalive on May 3, 1951, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

W. Howard Jeger M.D. Hagerstown, Md.May 4, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 6, 1951</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>May 5, 1951</u>	<u>Charles E. Evers</u>	<u>Scott F. Minnich & Son. Hag. Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05219

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>629 Oak Hill Avenue</u>		STREET ADDRESS (If rural, give location) <u>629 Oak Hill Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Alice</u>	(Middle) <u>Healey</u>	(Last) <u>Davis</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>8-14-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hub & Hutzler</u>	9. AGE last birthday <u>71</u> yrs. If under 1 year Months <u>9</u> Days <u>9</u> If under 24 hrs Hours <u>9</u> Min. <u>9</u>
11. BIRTHPLACE (State or foreign country) <u>Linwood, Carroll Co. Md.</u>		12. CITIZEN OF WHAT <u>United States</u>	
13. FATHER'S NAME <u>Thomas Milton Healey</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Richard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>218-145365</u>	
17. INFORMANT AND ADDRESS <u>Mrs. J. J. Funk, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Arterio-sclerotic coronary heart disease</u> Antecedent cause(s) (b) <u>Acute coronary occlusion</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>acute ventricular Fibrillation</u>			<u>Oct. 1950</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>NO</u>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>S. Robert M. Wells M.D.</u>		ADDRESS <u>115 N. Potomac</u> DATE SIGNED <u>May 18 '51</u>	
DEPUTY MEDICAL EXAM. <u>WASH. CO. MD.</u>		<u>Hagerstown, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-19-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 22, 1951</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	24. FUNERAL DIRECTOR <u>C. M. Suter & Sons, Hagerstown, Md.</u>	

390646

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05220

Reg. Dist. No. 303

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Big Spring Md. Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Big Spring, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Residence McCoy's Ferry		STREET ADDRESS (If rural, give location) McCoys Ferry	
3. NAME OF DECEASED (First) (Middle) (Last) William Amos Everitts		4. DATE (Month) (Day) (Year) OF DEATH May 12, 1951 19	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 1891 86 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired C & O Canal Employee		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 84 yrs.
11. BIRTHPLACE (State or foreign country) Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Everitts		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Lewis H. Everitts		Big Pool, Md.	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Chr. Myocardial Sclerosis			3 months
Antecedent cause(s) (b) Arterial Sclerosis			7 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) General			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General Muscular Atrophy			10 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 2, 1951, to May 12, 1951, that I last saw the deceased alive on May 11, 1951, and that death occurred at 4 P. M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
David R. Brewer M.D. Clear Spring Md. 5/15/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 15, 1951	NAME OF CEMETERY OR CREMATORY Shanktown Cem.	LOCATION (City, town, or county) Near Big Pool, Md.
DATE REC'D BY LOCAL REG. May 15, 1951	REGISTRAR'S SIGNATURE J. W. Murray	24. FUNERAL DIRECTOR WV 545	ADDRESS Clear Spring Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AT3

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Zimmerman

CERTIFICATE OF DEATH

Reg. Dist. No. 05221 30.1

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> TOWN <u>Williamsport</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>123 So. Artizan St</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> TOWN <u>Williamsport</u> STREET ADDRESS (If rural, give location) <u>123 So Artizan St.</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH</u> (First) <u>MAY</u> (Middle) <u>FOLTZ</u> (Last)		4. DATE OF DEATH <u>May 31 1951</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>May 16 1882</u> (Month) (Day) (Year)
9. AGE last birthday <u>69</u> yrs.		10. AGE last birthday <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Victor Neikirk</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Neikirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Otho S. Foltz Williamsport Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocarditis Chronic

INTERVAL BETWEEN ONSET AND DEATH

1945

Antecedent cause(s)

(b) 260X Disease or conditions, if any, giving rise to the above cause stating the underlying cause last(c) Diabetes 2 Hypertension rightII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1945, 19....., to May 31, 1951, that I last saw the deceasedalive on May 30, 1951, and that death occurred at 11 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6-3-51</u>	<u>Green Lawn Cemetery</u>	<u>Williamsport Wash. Co</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>June 3-51</u>	<u>E Lee McElroy</u>	<u>Andrew K. Coffman Hagerstown Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05222

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sharpsburg, RFD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Sharpsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Richard</u> <u>Henry</u> <u>Ford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>13</u> <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1889??</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62 ??</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-16-6650</u>	
17. INFORMANT AND ADDRESS <u>Joseph Ford</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute mycoardial failure

INTERVAL BETWEEN ONSET AND DEATH

1 hour

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Myocarditis, arteriosclerotic2 yrs.(c) Chronic Asthmatic bronchitis with2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Plural effusion

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from March 1, 1951, to May 13, 1951, that I last saw the deceased alive on May 9, 1951, and that death occurred at 4 p.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 15, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Pooles Tract</u>	LOCATION (City, town, or county) <u>Dickerson, Md.</u>	(State) <u>M.D.</u>
DATE REC'D BY LOCAL REG. <u>May 14, 1951</u>	REGISTRAR'S SIGNATURE <u>Elmer W. Boyer</u>	24. FUNERAL DIRECTOR <u>William B. Hilton</u>	ADDRESS <u>William W. Hilton, Barnesville, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 14 1951
BUREAU K. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05223

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>904 Salem Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Bessie</u> (First)	<u>Alice</u> (Middle)	<u>Foreman</u> (Last)	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>30</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>16 Oct. 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob D. Shetron</u>		14. MOTHER'S MAIDEN NAME <u>Ella Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Raymond Hart Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Intestinal Obstruction

Antecedent cause(s)

(b)

Carcinoma of sigmoid

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

Carcinoma of uterus (operated)II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Hypertension. Myocarditis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 24, 1951, to May 30, 1951, that I last saw the deceasedalive on May 29, 1951, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1954
BUREAU 7.3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Hoffman

05224

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>101 Broadway</u>		STREET ADDRESS (If rural, give location) <u>101 Broadway</u>	
3. NAME OF DECEASED (Type or Print) <u>MARY KATHERINE FUNK</u>		4. DATE OF DEATH <u>May 14 1951</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH <u>Oct 27 1860</u>	
9. AGE <u>90</u> yrs.		10. AGE last birthday <u>90</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. co. Md USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anna Spessard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Mary F. Dunn Hagerstown Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Coronary Thrombosis1 day

Antecedent cause(s)

(b) Arteriosclerosis - Generalized4 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 13, 1951, to May 14, 1951, that I last saw the deceased alive on May 14, 1951, and that death occurred at 9:45 A.m., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-16-51</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 15, 1951</u>	<u>Chas. A. Hoffman</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 2-15

RECEIVED
MAY 17 1951
BUREAU - 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05225

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> TOWN <u>HAGERSTOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON CO. HOSPITAL</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>SMITHSBURG</u> TOWN <u>SMITHSBURG</u> STREET ADDRESS (If rural, give location) <u>RURAL</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANKLIN</u>		(First) <u>CLIFFORD</u>		(Last) <u>GARDINER</u>		4. DATE OF DEATH <u>MAY - 22 - 1951</u> (Month) (Day) (Year)	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>APRIL - 22 - 1877</u> 9. AGE last birthday <u>74 - 1 - 0</u> yrs. Months Days Hours Mfn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTAL CLERK - R.M.S.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR BALTIMORE MD.</u>	
13. FATHER'S NAME <u>SAMUEL F. GARDINER</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA F. BERNER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>GEORGE GARDINER - 751 UPSAL ST. S.E. WASH. D.C.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>UREMIA</u>						<u>6 mos.</u>	
Antecedent cause(s) (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						<u>Years</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIOSCLEROSIS.</u>						<u>Years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <u>SUICIDE</u>				PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>_____</u> m.				INJURY OCCURRED While at <u>Work</u> Not While <u>At work</u>			
				HOW DID INJURY OCCUR? <u>_____</u>			
22. I hereby certify that I attended the deceased from <u>JAN.</u> , 19 <u>51</u> , to <u>22 MAY</u> , 19 <u>51</u> ; that I last saw the deceased alive on <u>21 MAY</u> , 19 <u>51</u> , and that death occurred at <u>8:30 A.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wilson</u>				(Degree or title) <u>M.D.</u>		ADDRESS <u>SMITHSBURG, MD.</u>	
						DATE SIGNED <u>5/23/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>MAY - 25 - 1951</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		LOCATION (City, town, or county) <u>WASHINGTON D.C.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 24, 1951</u>		REGISTRAR'S SIGNATURE <u>Dr. Wilson</u>		24. FUNERAL DIRECTOR <u>W.M. F. BAST AND SONS</u>		ADDRESS <u>BOONSBORO MD.</u>	

380906

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MAY 29 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05226 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1025 Beechwood Drive</u>	
3. NAME OF DECEASED (First) <u>Margaret</u> (Middle) <u>Laura</u> (Last) <u>Gibney</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-14-1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>32</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Curvin J. Stine</u>		14. MOTHER'S MAIDEN NAME <u>Iva H. ull</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Ralph I. Gibney, Jr.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

682X

Antecedent cause(s)

148a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

Pulmonary Thrombosis, et
Phlebotrombosis, femoral

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 hrs.3-5 days??II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.None. Post partum and

19a. DATE OF OPERATION

5-22-51

19b. MAJOR FINDINGS OF OPERATION

Bilat. partial salpingectomy

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-20, 1951, to 5-25, 1951, that I last saw the deceasedalive on 5-25, 1951, and that death occurred at 8:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

ROBERT F. KEADLE

DATE SIGNED

Robert F. KeadleMD132 W. WASHINGTON ST.5-26-51

23. BURIAL CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

5-28-1951

NAME OF CEMETERY OR CREMATORY

Rose Hill CemeteryHAGERSTOWN, MARYLAND

(State)

DATE REC'D BY LOCAL REG.

May 28, 1951

REGISTRAR'S SIGNATURE

Charles H. Gowers

24. FUNERAL DIRECTOR

C. M. Suter & Sons, Hagerstown, Md.

ADDRESS

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05227 306

1. PLACE OF DEATH- COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cascade</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ritchie Hospital</i>		STREET ADDRESS (If rural, give location) <i>11316 Kemp Mill Road</i>	
3. NAME OF DECEASED (Type or Print) <i>Martha</i> (First) <i>Alfaretta</i> (Middle) <i>Gray</i> (Last)		4. DATE OF DEATH <i>May</i> (Month) <i>3</i> (Day) <i>1951</i> (Year)	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Oct. 10, 1905</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cleaners & Dyers</i>	9. AGE last birthday <i>45</i> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Theodore Moore</i>		14. MOTHER'S MAIDEN NAME <i>Annie ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>unk.</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-16-1686</i>	
17. INFORMANT AND ADDRESS <i>Mr. Edward C. Gray</i>		18. MEDICAL CERTIFICATION <i>Silver Spring, Md.</i>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Carcinoma of Breast with generalized metastasis.*

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Sept. 6, 1950*, to *May 3, 1951*, that I last saw the deceased alive on *May 3, 1951*, and that death occurred at *7:30 a.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Daniel Lai**M.D.**Ritchie Hospital, Cascade, Md.*

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

*Burial**5/6/51**Colesville Cemetery**Montgomery County**Md.*

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*5/9/51**John A. Carraway**Wm. E. Pumphrey, 8434 G. Ave., Silver Spring, Maryland*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 11 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

05228

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Richard</u>	(Middle) <u>Lee</u>	(Last) <u>Griffith</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>7</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 6, 1951</u>
9. AGE last birthday <u>2</u> yrs.		10. If under 1 year: Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Donald Wm. Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Ester May Clevenger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Donald W. Griffith Funkstown, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pre maturity</u>		
Antecedent cause(s) (b) <u>Weight - 11 lb 3 oz</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 6, 1951, to May 7, 1951, that I last saw the deceased

alive on May 7, 1951, and that death occurred at 9:25 p.m., from the causes and on the date stated above.

SIGNATURE <u>F. S. Kraiss</u>	(Degree or title)	ADDRESS <u>Hagerstown, Maryland</u>	DATE SIGNED <u>May 8, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 9 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REG <u>May 9, 1951</u>	REGISTRAR'S SIGNATURE <u>Frederick W. Kraiss</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>	ADDRESS <u>Hagerstown, Md.</u>

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

Dr. Hoffman

05229

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharpsburg Pike</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>Sharpsburg Pike</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>FLORENCE</u>	(Middle) <u>CATHERINE</u>	(Last) <u>GROVE</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>3/7/1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cavetown Md.</u>
13. FATHER'S NAME <u>Cullen Barr</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Doub</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Earl B. Grove Hagerstown Md</u>	
16. SOCIAL SECURITY NO. <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Broncho Pneumonia

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart Disease

yrs.

(c) Arteriosclerosis

yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 10, 1951, to May 13, 1951, that I last saw the deceasedalive on May 13, 1951, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/15/51</u>	<u>Rest Haven Cemetery</u>	<u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 15, 1951</u>	<u>Phar H. Howers</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05230 361

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 N. Artizan St.</u>		STREET ADDRESS <u>9 N. Artizan Street</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Helen</u>	<u>Dugan</u>	<u>Harsh</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Oct. 3 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Housewife</u>		<u>Home</u>	<u>Nashville Tenn</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>John A. Dugan</u>		<u>Mary Jane Stake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
<u>No</u>		<u>None</u>	<u>9 N. Artizan St</u> <u>Mr. Albert S Harsh Williamsport Md.</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

422.2

Antecedent cause(s)

93d

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(a) Myocarditis(b) None known.

(c)

INTERVAL BETWEEN
ONSET AND DEATH

3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19....., to May 7, 1951, that I last saw the deceased alive on May 6, 1951, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 10-1951E. Lee McElroyAlbert Leaf Williamsport Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
MAY 14 1951
BUREAU V. S.

Dr. Brewer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05231

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>812 Salem Ave.</u>		STREET ADDRESS (If rural, give location) <u>812 Salem Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOSEPH</u>	(Middle) <u>MEROTN</u>	(Last) <u>HART</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 23, 1864</u>
9. AGE last birthday <u>87</u> yrs.		4. DATE OF DEATH <u>May 10 1951</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed Big Pool Md.</u>	
13. FATHER'S NAME <u>Henry P. Hart</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>James F. Hart, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chr. Endocarditis

INTERVAL BETWEEN ONSET AND DEATH

2 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Broncho Pneumonia2 months(c) Arterio Sclerosis10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 15, 1951, to Mar 11, 1951, that I last saw the deceasedalive on May 9, 1951, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/12/51</u>	<u>Shanktown Church Cem.</u>	<u>Shanktown, Wash. Co. Md.</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 16 1951</u>	<u>Dr. H. H. Brewer</u>	<u>Andrew A. Coffman</u>	<u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290 699

RECEIVED
MAY 14 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH Dr. LeVan

2411 N. Charles Street, Baltimore

05232

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH CITY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Cty. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>831 View St.</u>	
3. NAME OF DECEASED (Type or Print) First Middle Last <u>Samuel</u> <u>Hartshorne</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>5</u> <u>1951</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Mar. 9, 1871</u>	9. AGE last birthday <u>80</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic - Self</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hartshorne</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Shafer</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>148-10-1302</u>
17. INFORMANT AND ADDRESS <u>William S. Hartshorne</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral EmboliAntecedent cause(s) (b) Chronic MyocarditisDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 93d

INTERVAL BETWEEN ONSET AND DEATH

12 hrs3 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 22, 1951, to May 5, 1951, that I last saw the deceased alive on May 4, 1951, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-7-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 7, 1951</u>	REGISTRAR'S SIGNATURE <u>W. S. Hartshorne</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

554246

RECEIVED
MAY 1951
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

05233

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS (If rural, give location) <u>2510 W. Franklin St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Annie</u>	(Middle) <u>Minerva</u>	(Last) <u>Higgins</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>1</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 11, 1888</u>
9. AGE last birthday <u>62</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ritchie's Tavern</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>James H. Preston</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>215-24-1948</u>	17. INFORMANT AND ADDRESS <u>Hospital Record.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Adenocarcinoma of Uterus & Metastasis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart DiseaseII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 30, 1951, to May 1, 1951, that I last saw the deceased alive on May 1, 1951, and that death occurred at 10:55 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION (REMOVAL) (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/5/51</u>	<u>New Cathedral</u>	<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/3/51</u>	<u>A. W. Hedrick</u>	<u>Wm. J. Tickenner & Sons</u>	<u>Baltimore</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>226 N. Jonathan Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY ELIZABETH JONES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5 / 5 / 1951</u>	
5. SEX <u>Female</u> COLOR OR RACE <u>Negro</u>		6. DATE OF BIRTH <u>5/12/1889</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		9. AGE last birthday <u>61</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Jones</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Cula Harris - Philadelphia Pa.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X Immediate cause (a)

Carcinoma of Colon

462

Antecedent cause(s)

(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Secondary Anemia

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 5, 1951 to May 5, 1951 that I last saw the deceasedalive on May 5, 1951 and that death occurred at 5/5/51 m., from the causes and on the date stated above.

SIGNATURE

(Print or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 8, 1951Frank W. BowersWilliam H. Danner 2812 Endrick St

220826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05235

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Keedysville		CITY (If outside corporate limits, write RURAL and give nearest town) Keedysville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Albert	(Middle) Clayton	(Last) Kefauver
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1/24/1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	9. AGE last birthday 75 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Frederick county--Md		12. CITIZEN OF WHAT COUNTRY U.S	
13. FATHER'S NAME Dawson G. Kefauver		14. MOTHER'S MAIDEN NAME Virginia Shafer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Miss Mary Kefauver-Keedysville, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) _____

Angina Pectoris

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from **May 29**, 19**51**, to **May 29**, 19**51**, that I last saw the deceasedalive on **May 29**, 19**51**, and that death occurred at **12:30 AM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

R. I. Earnshaw--Keedysville, Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

RECEIVED
JUN 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05236

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *323*

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Hagerstown Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown Rt. #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #2</u>		STREET ADDRESS (If rural, give location) <u>R. F. D. #2</u>	
3. NAME OF DECEASED (Type or Print) <u>Sallie Hitchcock Ruback</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 25 1874</u>
9. AGE last birthday <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Dry Run Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fredrick Ruback</u>		14. MOTHER'S MAIDEN NAME <u>Martha Rowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Fred Keyser Hagerstown RFD #2 Maryland</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Acute Miliary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

2 months

Antecedent cause(s)

(b)

Influenza - Feb. 1951

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 15, 1951, to May 10, 1951, that I last saw the deceasedalive on May 10, 1951, and that death occurred at 7:05 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

David R. Brewer M.D. Clear Spring Md.

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 13 1951Broadfording Cemetery Hagerstown RFD #2 MdAlbert L. Leaf Williamsport Md.May 12-51Greg M. FackelLeft

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05237

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Sharpsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Sharpsburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Catherine</u> (Middle) <u>Altoona</u> (Last) <u>Kipe</u>		(Month) <u>May</u> (Day) <u>25</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 27, 1862</u>
9. AGE last birthday <u>88</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick County-Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. McClain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Flora Poffenberger</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Cerebral hemorrhage</u>	<u>7 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized arteriosclerosis and hypertension</u>	<u>10 Yrs.</u>
(c) <u>Fracture of the right hip</u> <u>Chronic cholecystitis & Cholelithiasis</u>		<u>10 month</u> <u>10 Yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>accident</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>home</u>	(CITY OR TOWN) <u>Sharpsburg</u>	(COUNTY) <u>Washington</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	<u>July 15 1950</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Slipped and fell in yard.</u>		

22. I hereby certify that I attended the deceased from 7/15, 1950, to 5/25, 1951, that I last saw the deceased alive on 5/25/51, 1951, and that death occurred at 1 P., from the causes and on the date stated above.

SIGNATURE Walter H. Shaly M.D. ADDRESS Sharpsburg, Md. DATE SIGNED 5/26/51.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5/28/51</u>	<u>Mt. View</u>	<u>Sharpsburg, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 26 1951</u>	<u>Elmer Boyer</u>	<u>R. I. Earnshaw--</u>	<u>Keedysville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Williamsport, Md. 2 wks		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Clear Spring	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pinesburg Road		STREET ADDRESS (If rural, give location) R D 2	
3. NAME OF DECEASED (Type or Print) Cora Lee Leigh		4. DATE OF DEATH (Month) (Day) (Year) May 15, 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 17-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE last birthday 77 yrs.
11. BIRTHPLACE (State or foreign country) ----- Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ----- Thomas		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Mrs. John Bowers- Williamsport, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary occlusion, acute			36 hours
Antecedent cause(s) (b) Hypertensive arteriosclerotic heart disease			unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Carcinoma of the colon			unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from February 11, 1942, to May 15, 1951, that I last saw the deceased alive on May 14, 1951, and that death occurred at 6:40 A.M., from the causes and on the date stated above.

SIGNATURE *Arthur B. Bowers* M D ADDRESS Clear Spring, Maryland DATE SIGNED 5-16-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 17 1951	NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	LOCATION (City, town, or county) Clear Spring, Md.	(State)
DATE REC'D BY LOCAL REG. May 17/51	REGISTRAR'S SIGNATURE <i>J. W. Murray</i>	24. FUNERAL DIRECTOR <i>Arthur B. Bowers</i>	ADDRESS Clear Spring Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 12 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Counter signed
May 5-51
DEPUTY MEDICAL EXAM,
WASH. CO., MD.

S. Robert Walls M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Victor Miller

05239

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH CITY <u>Washington</u> COUNTY <u>MARYLAND</u>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Virginia Ave Extd</u>			STREET ADDRESS (If rural, give location) <u>Virginia Ave Extd.</u>		
3. NAME OF DECEASED (Type or Print) <u>LILLIAN LANDIS LISKEY</u>			4. DATE OF DEATH <u>May 3 1951</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>			8. DATE OF BIRTH <u>July 26 1885</u>		
9. AGE last birthday <u>65</u> yrs.			10. If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
11. BIRTHPLACE (State or foreign country) <u>Marlowe Berkeley Co W. Va.</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13. FATHER'S NAME <u>Joseph Landis</u>			14. MOTHER'S MAIDEN NAME <u>Rebecca Ripple</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY No. <u>None</u>		
17. INFORMANT AND ADDRESS <u>R. Browne Liskey Sr.</u>					

18. MEDICAL CERTIFICATION Hagerstown Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Endocarditis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arterio. Sclerosis

(c) Patient attended by son (Chiropractor)

INTERVAL BETWEEN ONSET AND DEATH

6-7 years

21

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

0

19b. MAJOR FINDINGS OF OPERATION

0

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?							
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>									

22. I hereby certify that I attended the deceased from 5/3, 1951, to 5/3, 1951, that I last saw the deceased alive on 4-5 years ago, and that death occurred at 5/3, 1951, from the causes and on the date stated above.

SIGNATURE

DR. VICTOR D. MILLER

ADDRESS

DATE SIGNED

V. D. Miller

131 W. WASHINGTON ST.

HAGERSTOWN, MD.

5/3-1951

23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>5/5/51</u>		<u>River View Cemetery</u>		<u>Williamsport Md.</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>May 5, 1951</u>		<u>S. Robert Walls</u>		<u>Andrew K. Coffman</u>		<u>Hagerstown Md</u>			

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

05240

1. PLACE OF DEATH - COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>BOONS BORO</u>			
TOWN <u>SAN MAR</u>				TOWN <u>BOONS BORO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FAHRNEY MEMORIAL HOME</u>				STREET ADDRESS (If rural, give location) <u>MAIN ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>EDITH</u> <u>BALINDA</u> <u>LONG</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY</u> - <u>23</u> - <u>1951</u>			
5. SEX <u>FEMALE</u>				6. COLOR OR RACE <u>WHITE</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>				8. DATE OF BIRTH <u>JULY - 1 - 1864</u>			
9. AGE last birthday <u>86-10-22 yrs.</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			
11. BIRTHPLACE (State or foreign country) <u>UNION BRIDGE MD.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>EPHRAIM STONER</u>				14. MOTHER'S MAIDEN NAME <u>BALINDA ENGLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT AND ADDRESS <u>MRS. HENRY H. BRECHBILL - COLLEGE PARK MD.</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis -</u>							<u>6 mon</u>
Antecedent cause(s) (b) <u>122.2 Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
Other significant conditions (c) <u>93d</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)			(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>April 5</u> , 19 <u>51</u> , to <u>May 23</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>51</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				(Degree or title) <u>M.D.</u>		ADDRESS <u>Boonsboro -</u>	
DATE SIGNED <u>5/25/51</u>							
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>MAY - 26 - 1951</u>		NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>		LOCATION (City, town, or county) <u>NR. TILGHMANTON MD</u>	
DATE REC'D BY LOCAL REG. <u>May 26, 1951</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. R. BAST AND SONS</u>		ADDRESS <u>Boons Boro MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. L. J. Jones

RECEIVED
MAY 31 1951
BUREAU X. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>424 N. Jonathan Street</u>	
3. NAME OF DECEASED (First) <u>FRANK</u> (Middle) <u>VERNON</u> (Last) <u>LONG</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/14/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lumber Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Portsmouth, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Benjamin Long</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-16-2912</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lena Long 424 N. Jonathan Street</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Cerebral embolism</u>	INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
Antecedent cause(s) (b) <u>Pneumonia & effusion</u>	<u>2 wks</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Acute pneumonia & effusion</u>	<u>2 days</u>

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 29, 1951 to May 5, 1951, that I last saw the deceasedalive on May 4, 1951, and that death occurred at 10:30 p.m. from the causes and on the date stated above.SIGNATURE Phyllis M. McLean (Degree or title) MD ADDRESS Hagerstown, Md. DATE SIGNED 5/7/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/8/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>May 8, 1951</u>	REGISTRAR'S SIGNATURE <u>Phyllis M. McLean</u>	24. FUNERAL DIRECTOR <u>William H. Brown</u>	ADDRESS <u>2912 Endrick St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No positive test for tuberculosis obtained. 9-10-51 Dr. Hirshman. (ams)

RECEIVED

MAY 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05242

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mason & Dixon</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hosp.</u>		STREET ADDRESS <u>Greencastle Rt. #1</u>	
3. NAME OF DECEASED (Type or Print) <u>Lena</u> (First) <u>R.</u> (Middle) <u>Martin</u> (Last)		4. DATE OF DEATH <u>May 3</u> (Month) <u>3</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/2/1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>2</u> yrs. <u>1</u> month <u>1</u> day
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Seth Martin</u>		14. MOTHER'S MAIDEN NAME <u>Marian Rissler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Seth Martin</u>		<u>Mason & Dixon</u> <u>Ranka</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Convulsion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) ARACHNOIDITIS

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/26, 1951, to 2/3, 1951, that I last saw the deceased(alive on 5/3, 1951, and that death occurred at 2:30 AM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

203021294405

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05243

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>21 S. Potomac St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>WILLIAM</u> (Middle) <u>ADRON</u> (Last) <u>MARTIN</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 7, 1886</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner-Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Storage Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Bentonville, Warren Co. Va. USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Robert H. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Sarah F. Lake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Maude Martin, Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary insufficiency

INTERVAL BETWEEN ONSET AND DEATH

1 hr 20 min

Antecedent cause(s)

(b) Hypertensive cardiovascular disease10 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Arteriosclerosis (Ischemic)10 yearsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Pulmonary Tuberculosis1 1/2 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

1 1/2 years

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct. 1945, to May 19, 1951, that I last saw the deceased alive on May 19, 1951, and that death occurred at 1:40 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 21, 1951</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Layman, Jr.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 23 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Ditto

05244

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 1</u> TOWN <u>Hagerstown R # 1</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beaver Creek</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # X1</u> TOWN <u>Hagerstown R # X1</u> STREET ADDRESS (If rural, give location) <u>Beaver Creek</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM</u> (First) <u>McCAULEY</u> (Middle) <u>McCAULEY</u> (Last)		4. DATE OF DEATH May 9 1951 (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widower</u>	8. DATE OF BIRTH Feb 22 1867 (Month) (Day) (Year)
9. AGE last birthday 84 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Wash. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME <u>Charles McCauley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Newcomer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Preston T. Smith</u>		18. MEDICAL CERTIFICATION <u>20 North Ave Hagerstown Md</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Disease</u>		<u>2 years</u>	
Antecedent cause(s) (b) <u>Heart Disease</u>		<u>10 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-1</u> , 19 <u>51</u> , to <u>5-9</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-4</u> , 19 <u>51</u> , and that death occurred at <u>2 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>A. J. W. Ditto</u>		ADDRESS <u>Hagerstown Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE TIME OF <u>5/11/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Beaver Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Beaver Creek Md</u>	
DATE REC'D BY LOCAL REG. <u>May 10, 1951</u>		REGISTER'S SIGNATURE <u>John H. Baer</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 15 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05245

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1001 Salem Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Lulu Virginia Snapp</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 9, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Alma Page Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jefferson Dovel</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Kite</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Harvey Morris Hag. Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Chronic Myocarditis</u>		<u>1 yr</u>	
Antecedent cause(s) (b) <u>93d</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>General Arterio Sclerosis</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 1, 1951</u> , to <u>May 28, 1951</u> , that I last saw the deceased alive on <u>May 28, 1951</u> , and that death occurred at <u>9:10 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. D. Beatty M.D.</u>		ADDRESS <u>Hagerstown Md</u> DATE SIGNED <u>5/28/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 31, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 31, 1951</u>		24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son Hag. Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

15246

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna.</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Mauginsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>rural Greencastle</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mauginsville Menonite Home</u>		STREET ADDRESS (If rural, give location) <u>Rt. 2 Greencastle, Pa.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u> (Middle) <u>Myers</u> (Last) <u>Miller</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>9</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 21, 1862</u>
9. AGE last birthday <u>88</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>John S. Myers</u>	14. MOTHER'S MAIDEN NAME <u>Mary Hollinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY No. <u>215-26-1811</u>	17. INFORMANT AND ADDRESS <u>Mrs. Henry Hosteter, Mauginsville, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 X Immediate cause	(a) <u>Arteriosclerotic cardio vascular-renal disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>
Antecedent cause(s) 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) _____	
(c) _____		

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 1939, to 5/9, 1951, that I last saw the deceased alive on 5/8, 1951 and that death occurred at 5:00 a.m., from the causes and on the date stated above.

SIGNATURE _____ (Degree or title) ADDRESS _____ DATE SIGNED _____

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 12, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Dunkard Church Cemetery</u>	LOCATION (City, town, or county) <u>Welsh Run, Pa.</u>	(State) <u>Franklin Co.</u>
DATE REC'D BY LOCAL REG. <u>May 10, 1951</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	24. FUNERAL DIRECTOR <u>Harold M. Zimmerman, Greencastle, Pa.</u>		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sharpsburg Md.</u> LENGTH OF STAY (in this place) <u>8 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sharpsburg Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street Sharpsburg</u>		STREET ADDRESS (If rural, give location) <u>Main Street</u>	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>Harrison</u> (Last) <u>Mose</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 19 1887</u>
9. AGE last birthday <u>63</u> yrs. If under 1 year Months <u>5</u> Days <u>5</u> If under 24 hrs. Hours <u>5</u> Min. <u>15</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Rail Roader Blacksmith</u>	
11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Mose Jacob Mose</u>		14. MOTHER'S MAIDEN NAME <u>Ada Ecton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>705-10-4603</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Hilda Mose Sharpsburg Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1 hour

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Arteriosclerotic heart disease15 Yrs.(c) Diabetes mellitus15 Yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1949, 19....., to 5/27/51, 19....., that I last saw the deceased alive on 5/20/51, 19....., and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 31 1951</u>	<u>View Cemetery</u>	<u>Sharpsburg Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-21-51</u>	<u>Edw. B. B. B.</u>	<u>Albert L. Leaf Williamsport Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05248

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>6 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29A - N. Foundry St.</u>		STREET ADDRESS (If rural, give location) <u>29A North Foundry St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mollie Thomas Munday</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 18, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-24-78</u>
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Paul Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth — (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Mrs. Lottie Thomas (daughter)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Coronary occlusion</u>		<u>1 hr.</u>
Antecedent cause(s)	(b) <u>Arteriosclerosis, Heart Disease</u>		<u>Years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>April 1950</u> , to <u>May 18, 1951</u> , that I last saw the deceased alive on <u>May 1st</u> , 19 <u>51</u> , and that death occurred at <u>530 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Shirley Medema M.D.</u>		ADDRESS <u>Hagerstown Md</u>	
DATE <u>May 20, 1951</u>		DATE SIGNED <u>5/19/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>5-21-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Clearspring, Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>May 20, 1951</u>		24. FUNERAL DIRECTOR <u>Charles R. Bast, Hancock, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 22 1951
BUREAU A R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH— COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>18 N. Conococheague St.</u>		STREET ADDRESS (If rural, give location) <u>18 N Conococheague Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Percy McKendrick</u>		4. DATE OF DEATH <u>May 28 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 4 1895</u>
9. AGE last birthday <u>55</u> yrs.		10. If under 1 year: Months <u>5</u> Days <u>28</u> Hours <u>28</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Grocery Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Murray</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Carrie Murray 18 N. Conococheague Williamsport Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

229X Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause,
stating the underlying cause last

562

(a) Multiple Myeloma & Carcinomatosis 1950
(b) no other diagnosis confirmed
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb., 1951, to May 28, 1951, that I last saw the deceased alive on May 28, 1950, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 1-51Lee McElroyAlbert L. Leaf Williamsport Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05250
Reg. Dist. No. 307

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Hook</u> TOWN <u>(Rural) Sandy Hook</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Residence</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Hook</u> TOWN <u>(Rural) Sandy Hook</u> STREET ADDRESS (If rural, give location) <u>R.F.D. #1, Knoxville, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN CHARLES EDWARD NUCE</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 17, 1877</u>
9. AGE last birthday <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R. Co.</u>
11. BIRTHPLACE (State or foreign country) <u>Loudoun County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Nuce</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hawk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>705-07-7723</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Martha Nuse</u>		<u>R.F.D. #1, Knoxville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>4 hours</u>
Antecedent cause(s) (b) <u>congestive heart failure & hypertension</u>		<u>2 weeks</u>
(c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on May 31, 1951, and that death occurred at 4:25 P.m., from the causes and on the date stated above.

SIGNATURE William W. Orrison M.D. ADDRESS Brunswick Maryland DATE SIGNED June 1, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>	LOCATION (City, town, or county) (State) <u>Loudoun County, Virginia</u>
DATE REC'D BY LOCAL REG. <u>6/2/51</u>	REGISTRAR'S SIGNATURE <u>Donaldis R. Castle</u>	24. FUNERAL DIRECTOR <u>Melvin T. Stuber, Charles Town</u>	ADDRESS <u>970506</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05251

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>215 Summit Avenue</u>		STREET ADDRESS (If rural, give location) <u>215 Summit Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Catherine Mary Palladino</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 19 51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>6-13-1873</u>
9. AGE last birthday <u>77 yrs.</u>		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Mfn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Oakland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A. Walsh</u>		14. MOTHER'S MAIDEN NAME <u>Teresa Fink</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Angelo L. Palladino, Hagerstown, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Myocardial Infarction</u>		<u>3 mos</u>	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Coronary insufficiency</u>		<u>4 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-1-48</u> , 19 <u>48</u> , to <u>5/27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/20/51</u> , 19 <u>51</u> , and that death occurred at <u>5/20/51</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Ed Young MD</u>		ADDRESS <u>Hagerstown, Md</u>	
DATE SIGNED <u>May 29, 1951</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-30-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. M. Suter & Sons</u>		ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05252

Reg. Dist. No. 305

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u> TOWN <u>Boonsboro</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Guilford Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Franklin</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u> TOWN <u>Chambersburg</u> STREET ADDRESS (If rural, give location) <u>Chambersburg</u>	
3. NAME OF DECEASED (Type or Print) <u>Annie M. Patterson</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 4 - 1862</u>
9. AGE last birthday <u>89</u> yrs. <u>3</u> mos. <u>0</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, avon if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Herbert D. Patterson 327 E. Liberty St. Chambersburg Pa.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis</u>	<u>3 yrs.</u>
Antecedent cause(s) (b) <u>422.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	
(c) <u>93d</u>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May 1, 1951, to May 4, 1951, that I last saw the deceased alive on May 3, 1951, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	ADDRESS <u>Boonsboro</u>	DATE SIGNED <u>5/5/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 6, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Northland Cemetery</u>
LOCATION (City, town, or county) <u>Chambersburg</u>	(State) <u>Penn.</u>	
DATE REC'D BY LOCAL REG. <u>May 6, 1951</u>	REGISTRAR'S SIGNATURE <u>John H. Best</u>	24. FUNERAL DIRECTOR <u>Robert R. Barlow</u>
ADDRESS <u>Chambersburg Pa.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05253

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>250 S. Potomac St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Fanny Delaney Pennington</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/11/1889</u>
9. AGE last birthday <u>62 yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Talcoth Eliason</u>		14. MOTHER'S MAIDEN NAME <u>Berna Teresa Hanserth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Sarah Pennington Hagerstown Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary insufficiency</u>		<u>One month</u>	
Antecedent cause(s) (b) <u>Hypertensive - Cardiovascular Disease</u>		<u>appears</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Marked obesity</u>		<u>"</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 10, 1951</u> , to <u>May 11, 1951</u> , that I last saw the deceased alive on <u>May 11, 1951</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Richard T. Binford, M.D.</u>		DATE SIGNED <u>5-12-51</u>	
23. BURIAL, CREMATION REMOVE (Specify) <u>Burial</u>		DATE THEREOF <u>5/12/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 13, 1951</u>		24. FUNERAL DIRECTOR <u>W. J. Norment, Hagerstown, Md.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Richard T. Binford
1135 Potomac Ave.

3²⁰
PM.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>258 S. Potpmac St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>SARAH</u>	(Middle) <u>ELLEN</u>	(Last) <u>POPO</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>31</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	8. DATE OF BIRTH <u>Oct. 26, 1900</u>	9. AGE last birthday <u>50</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Samuel H. Rock</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Lloyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Philip Popo, Hagerstown Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)-----

Diabetes M

Antecedent cause(s)

(b)-----

Chr glomerular nephritis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)-----

arterio-sclerotic myocardial heart disease
myocardial heart failure grade Iv

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 9, 1939, to 5/31, 1951, that I last saw the deceasedalive on 5/31/51, 1951, and that death occurred at 11:05P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>June 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05255304

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Hancock</u> LENGTH OF STAY (in this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #1</u>		STREET ADDRESS (If rural, give location) <u>Route #1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Annie</u>	(Middle) <u>Rebecca</u>	(Last) <u>Resley</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>
8. DATE OF BIRTH <u>2-19-64</u>	9. AGE last birthday <u>87</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>James Resley</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Craig</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	16. SOCIAL SECURITY No. <u>—</u>	17. INFORMANT <u>Charles Barnhart</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a)..... <u>Cerebral Hemorrhage</u>		
Antecedent cause(s) (b)..... <u>Debility</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 15, 1951</u> to <u>May 16, 1951</u> , that I last saw the deceased alive on <u>May 16, 1951</u> , and that death occurred at <u>10:50 p.m.</u> from the causes and on the date stated above.		
SIGNATURE <u>L. M. Shaffer M.D.</u> (Degree or title)		ADDRESS <u>Hancock Md.</u> DATE SIGNED <u>5/17/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5-19-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u> LOCATION (City, town, or county) <u>Hancock</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>5/18/51</u>	REGISTRAR'S SIGNATURE <u>J. A. Keller</u>	24. FUNERAL DIRECTOR <u>Charles R. Bast, Hancock, Md.</u> ADDRESS

093888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COPY SENT TO LOCAL REGISTRAR No. _____



DATE 5-21-51

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05256

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>127 N. Mulberry Street</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>C.</u> (Last) <u>Reynolds</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 3, 1870</u>
9. AGE last birthday <u>81</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Albin</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Steffey</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Mary Barber Hagerstown, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Congestive Heart Failure</u>		<u>1 mo.</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Heart Disease</u>		<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>Healed fracture, right wrist</u>		<u>2 mo -</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
<u>ACCIDENT</u>	<u>Hagerstown, Md</u>	<u>Hagerstown, Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/20/51</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell out of bed</u>
22. I hereby certify that I attended the deceased from <u>4-15, 1940</u> , to <u>5-13, 1951</u> , that I last saw the deceased alive on <u>5/13, 1951</u> , and that death occurred at <u>7:40 p.m.</u> , from the causes and on the date stated above.		
SIGNATURE <u>John H. Hame Baker M.D.</u>		DATE SIGNED <u>5/14/51</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>May 16, 1951</u>	<u>Rest Haven Cemetery</u>
DATE REC'D BY LOCAL REG. <u>May 15, 1951</u>	REGISTRAR'S SIGNATURE <u>John H. Hame Baker</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>Fred W. Kraiss Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9020

4200

186a



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hancock, Md.</u> TOWN <u>Hancock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u> TOWN <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near R 40 Park Head Dist</u>		STREET ADDRESS (If rural, give location) <u>Near R 40 Park Head Dist.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sarah Belle Hidenour</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 20, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>John Reed</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Dickerhoof</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Daughter Mrs. Nellie Beavers- Herndon, Va.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinomatosis, generalized</u>			<u>unknown</u>
Antecedent cause(s) (b) <u>Adenocarcinoma, body of the uterus</u>			<u>2 years.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>172X 48b</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>January 11, 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma coprus uterus</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN) <u>Clear Spring, Maryland</u>	(COUNTY) (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 26 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Clear Spring, Md.</u>	

22. I hereby certify that I attended the deceased from 12-26-49, to 5-22-51, that I last saw the deceased alive on 4-8-51, 1951, and that death occurred at 8.00P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>May 26-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	LOCATION (City, town, or county) <u>Near Clear Spg. Md.</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>May 26 1951</u>		REGISTRAR'S SIGNATURE <u>J. W. Murray</u>	24. FUNERAL DIRECTOR <u>Clear Spring, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A13

RECEIVED
JUN 12 1951
BUREAU V. S.

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05258

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Washington</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hagerstown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Cty. Hospital</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hagerstown</u> TOWN STREET ADDRESS (If rural, give location) <u>117 S. Potomac St</u>			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
		<u>Jessie</u>		<u>Susan</u>		<u>Rowland</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>May 3, 1885</u>	
						9. AGE last birthday <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rudy's Pharmacy</u>		11. BIRTHPLACE (State or foreign country) <u>Union Bridge, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John M. Hollenberger</u>				14. MOTHER'S MAIDEN NAME <u>Lorraine Anders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Lois H. Rowland</u>	
18. MEDICAL CERTIFICATION <u>Hagerstown, Md.</u>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carcinoma Duodenum</u>						<u>2 yrs</u>	
Antecedent cause(s) (b) <u>175X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
Other significant conditions (c) <u>49a</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/5/51</u> , 19....., to <u>9/8/51</u> , 19....., that I last saw the deceased alive on <u>9/8/51</u> , 19....., and that death occurred at <u>11:40 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>S. W. Little</u>				ADDRESS <u>Hagerstown Md</u>		DATE SIGNED <u>9/8/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-10-51</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		LOCATION (City, town, or county) (State) <u>Union Bridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 9, 1951</u>		REGISTRAR'S SIGNATURE <u>W. H. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

390 669

RECEIVED
MAY 11 1961
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Ditto

05259

Reg. Dist. No.302.....

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Cty. Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Washington</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>643 W. Washington St.</u>			
3. NAME OF DECEASED (First) <u>Edgar</u>		(Middle) <u>Rumler</u>		(Last) <u>Saylor</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>10</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Nov. 25, 1889</u>	
9. AGE last birthday <u>61</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna Rwy. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>John Saylor</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	
16. SOCIAL SECURITY No. <u>716-09-8277</u>		17. INFORMANT AND ADDRESS <u>Howard F. Johnston</u>		18. MEDICAL CERTIFICATION <u>Hagerstown, Md.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Coronary (Vascular) Occlusion</u>							
Antecedent cause(s) (b) <u>420/1 94a</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <u>SUICIDE</u>				PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/14/51</u> , 19....., to <u>9/14/51</u> , 19....., that I last saw the deceased alive on <u>6/14/51</u> , 19....., and that death occurred at <u>2:00 P.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>J. W. Saylor</u>				ADDRESS <u>Hagerstown, Md.</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>5-12-51</u>			
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				LOCATION (City, town, or county) <u>Hagerstown, Md.</u>			
DATE REC'D BY LOCAL REG. <u>May 11, 1951</u>				24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>			
REGISTRAR'S SIGNATURE <u>Thomas H. Powers</u>				ADDRESS <u>Hagerstown, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 14 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05260

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- COUNTY <u>Maryland</u>		Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place) <u>56 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>On Street (Jefferson St.)</u>				STREET ADDRESS <u>334 North Cannon Avenue</u>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Bertie</u>		(First) <u>Estelle</u>		(Middle) <u>Shaw</u>		(Last)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>10-26-1877</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>73</u> yrs.		4. DATE OF DEATH <u>May</u> <u>31</u> <u>1951</u>	
11. BIRTHPLACE (State or foreign country) <u>Page County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joe Medden</u>		14. MOTHER'S MAIDEN NAME <u>Lallie Cullers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mrs. Dorothy Lettau, Hagerstown</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

Immediate cause

(a) Acute ventricular fibrillation

Antecedent cause(s)

Disease or condition, if any,
giving rise to the above cause
stating the underlying cause last(b) arterio-sclerotic myocardial heart disease

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURYINJURY OCCURRED
While at Nnt while
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

S. Robert Wells M.D.

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

125 N. Patomac
Hagerstown, Md.6/1/5123. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 3, 1951Charles H. BrownC. M. Suter & Sons, Hagerstown, Md.

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05261

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WAGERTSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TILGHMANTON</u>	
TOWN <u>WASHINGTON</u>		TOWN <u>TILGHMANTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON County Hospital</u>		STREET ADDRESS (If rural, give location) <u>MAIN ST.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MAUDE</u> (Middle) <u>DAISY</u> (Last) <u>SMITH</u>		4. DATE OF DEATH <u>MAY - 28 - 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 10 - 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>68-2-18</u> yrs. Months Days Hours Min.
13. FATHER'S NAME <u>ESTIAH SHORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>FRED SMITH BOONSBORO MD R. 2</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET ELLEN ROADENIZER</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic Myocarditis</u>		<u>2 yrs</u>
Antecedent cause(s) (b) <u>Double lobar pneumonia</u>		<u>10 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertensive arteriosclerosis.</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 27, 1951, to May 28, 1951, that I last saw the deceased alive on May 28, 1951, and that death occurred at 8:15 P m., from the causes and on the date stated above.

SIGNATURE W. H. H. H. (Degree or title) ADDRESS Boonsboro DATE SIGNED 5/30/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>MAY 31 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>	LOCATION (City, town, or county) <u>NR. TILGHMANTON MD.</u>
DATE REC'D BY LOCAL REG. <u>MAY 31, 1951</u>	REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	24. FUNERAL DIRECTOR <u>WILLIAM F. BAST AND SONS</u>	ADDRESS <u>BOONSBORO MD</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05262

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Breathedsville</u> LENGTH OF STAY (in this place) <u>3 Months</u> TOWN <u>Breathedsville</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marriottsville</u> Rural TOWN <u>Marriottsville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>HERBERT</u> (First) (Middle) (Last) <u>SNOWDEN</u>		4. DATE OF DEATH <u>May</u> (Month) <u>12</u> (Day) <u>19 51</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 4, 1924</u>
9. AGE last birthday <u>27</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Farm Hand</u>	
11. BIRTHPLACE (State or foreign country) <u>Marriottsville</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Marshall Snowden</u>		14. MOTHER'S MAIDEN NAME <u>Goldie Parks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unable to locate</u>	
17. INFORMANT AND ADDRESS <u>Records of State Reformatory for</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset and Death <u>7 mo.</u>	
Immediate cause (a) <u>Pulmonary Tuberculosis</u>			
Antecedent cause(s) (b) <u>002X</u> <u>138</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-23</u> , 19 <u>51</u> , to <u>May 12</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>51</u> , and that death occurred at <u>11:54</u> m., from the causes and on the date stated above.			
SIGNATURE: <u>Robert P. Conrad, M.D.</u>		ADDRESS: <u>Hagerstown, Md.</u>	
DATE SIGNED: <u>5-13-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/15/51</u>	
NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>		LOCATION (City, town, or county) <u>Near Alpha, Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 13, 1951</u>		REGISTRAR'S SIGNATURE <u>John D. East</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

820105

RECEIVED
MAY 18 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bonushow md. R.I.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> STREET ADDRESS <u>Bonushow md. R.I.</u>	
3. NAME OF DECEASED (Type or Print) <u>George Benjamin South</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 18, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>63-9-16 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Crk. Co. md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin G. South</u>		14. MOTHER'S MAIDEN NAME <u>Jane C. Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C.E. Rutzahn Bonushow md. R.I.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>421.4</u>	(a) <u>Chronic Nodular Endocarditis</u>	<u>17, 5-6 years</u>
Antecedent cause(s) <u>92d</u>	(b) <u>Arterio-sclerosis</u>	<u>" "</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Renal Calculus</u>	<u>2-3 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>0</u>		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION <u>0</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY <u>0</u>	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN) <u>0</u> (COUNTY) <u>0</u> (STATE) <u>0</u>
22. I hereby certify that I attended the deceased from <u>Jan 1, 1948</u> , to <u>May 4, 1951</u> , that I last saw the deceased alive on <u>April 25, 1951</u> , and that death occurred at <u>8 a.m.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Dr. Victor D. Miller</u> DR. VICTOR D. MILLER, WASHINGTON ST.		DATE SIGNED <u>5/5-1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 6, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Beaver Creek Cemetery</u>
DATE REC'D BY LOCAL REG. <u>May 5, 1951</u>	REGISTERAR'S SIGNATURE <u>John H. Best</u>	24. FUNERAL DIRECTOR <u>Wm. F. Best & Sons Bonushow md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05263

RECEIVED
JUN 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 E Church Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport Md.</u> STREET ADDRESS (If rural, give location) <u>17 E. Church Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Elgie</u> (First) <u>Costella</u> (Middle) <u>Sprinkle</u> (Last)	4. DATE OF DEATH <u>May 11</u> (Month) <u>1951</u> (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 20 1874</u>
9. AGE last birthday <u>76</u> yrs. If under 1 year Months <u>5</u> Days <u>20</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Sprinkle Mills W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clinton Sprinkle</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Welchans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Clara Sprinkle Williamsport Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocarditis Chronic

Antecedent cause(s)

(b)

None known

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19....., to May 11, 1951, that I last saw the deceased alive on May 11, 1951, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 13, 1951E Lee McElroyEdith V. Leaf Williamsport Md.

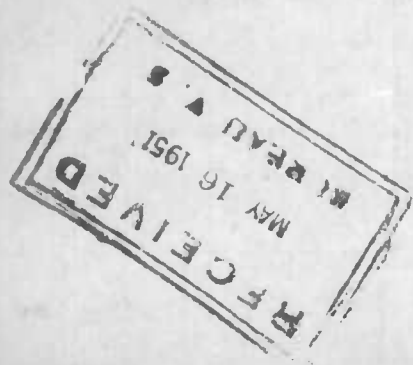
MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05264

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05265

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash/</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>122 S. Locust St.</u>		STREET ADDRESS (If rural, give location) <u>122 S. Locust St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Thomas</u>	(Last) <u>Staub</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>13</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investigator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Local Gov.</u>	8. DATE OF BIRTH <u>Apr. 27, 1889</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Highfield Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Charles W. Staub</u>		14. MOTHER'S MAIDEN NAME <u>Anna Galdhill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-07-0265</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Alice G. Staub</u>		<u>Hag. Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Vascular Hypertension5 yrs

Antecedent cause(s)

(b)

arterio-sclerotic myocardial degeneration

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

with congestive myocardial failure grade IV (1 year)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

auricular fibrillation7

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY noneINJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 5, 1951, to May 14, 1951, that I last saw the deceasedalive on 5/8, 1951, and that death occurred at 1:15 p. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

S. Robert Wells, M.D.115 N. Patomas St. Hagerstown, Md.5/14/51

23. BURIAL, CREMATION REMAINS (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 15, 1951Scott F. Minnich & SonHagerstown Md.Hag. Md.

300936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAY 17 1951
BUREAU A. I.

MARYLAND STATE DEPARTMENT OF HEALTH

05266

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>Life</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>1015 Oak Hill Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna</u> (First) <u>Miller</u> (Middle) <u>Storey</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>29</u> (Day) <u>1951</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-20-1876</u>	9. AGE last birthday <u>74</u> yrs. <u>6</u> Months <u>9</u> Days <u>9</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
13. FATHER'S NAME <u>John W. Storey</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Stover</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Miss Mary Storey, Hagerstown, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral thrombosis

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

(b)

Congestive heart failure6 days

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertensive cardiovascular renal diseaseUnknownII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 23, 1951 to May 25, 1951, that I last saw the deceased alive on May 28, 1951, and that death occurred at 2:00 P.M. on May 28, 1951, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-31-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 31, 1951</u>		REGISTRAR'S SIGNATURE <u>Christ H. Bowen</u>	24. FUNERAL DIRECTOR <u>C.M. Suter & Sons, Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

093888

Dr. Wm. Jayman

RECEIVED
JUN 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05267

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Myersville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cor Lincoln & Gay - Hagerstown</u>		STREET ADDRESS (If rural, give location) <u>Wolfsville</u>	
3. NAME OF DECEASED (First) <u>Edna</u> (Middle) <u>B.</u> (Last) <u>Stollenmyer</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-10-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Our Home</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>Wolfsville, Fred. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jonathan N. Wolfe</u>		14. MOTHER'S MAIDEN NAME <u>Almanda E. Blickenstaff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>G.P. Stollenmyer, Myersville Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardio Vascular Renal disease with

Antecedent cause(s)

(b) renal failure

(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify) MI PLACE (Home, farm, factory, street, OF office bldg., etc.) MI INJURYTIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1950, to 17 May, 1951, that I last saw the deceasedalive on 16 May, 1951, and that death occurred at 8:35 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) FuneralDATE THEREOF May 20-1951NAME OF CEMETERY OR CREMATORY United LutheranLOCATION (City, town, or county) Wolfsville, Fred. Co. Md.

(State)

DATE REC'D BY LOCAL REG. May 18, 1951REGISTRAR'S SIGNATURE Paul F. Bittle

24. FUNERAL DIRECTOR

ADDRESS

Paul F. Bittle, Myersville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JUN 21 1961
B. A. O'NEAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Beachley

05268 Jc3

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural Hagerstown</u> TOWN <u>Layman Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Virginia Ave.</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>STOUFFER</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>7/2/1865</u>
9. AGE last birthday <u>86</u> yrs.		4. DATE OF DEATH <u>May 17 1951</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>
11. BIRTHPLACE (State or foreign country) <u>Oak Orchard, Fred. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Devilbiss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Dr. John T. Ensor Baltimore 18, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 1945 to May 1951, that I last saw the deceased alive on May 17 1951, and that death occurred at 8 PM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>May 19 1951</u>	REGISTRAR'S SIGNATURE <u>Ray M. Feltz</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 12 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Victor Miller

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1621 Virginia Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>1621 Virginia Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>FRANKLIN ALLISON TRONE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 2 1880</u>
9. AGE last birthday <u>71</u> yrs.		10. AGE last birthday (If under 1 year) (If under 24 hrs.) Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silk Weaver Md. Ribbon Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St James Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benj. Trone</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rowland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6294</u>	
17. INFORMANT AND ADDRESS <u>William O. Renner</u>			

18. MEDICAL CERTIFICATION <u>1623 Virginia Ave Hagerstown Md.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year - 12/1</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Paralysis agitans</u>		
Antecedent cause(s) (b) <u>Thrombosis - cerebral vessels.</u>		<u>48 hours</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT (Specify) SUICIDE <u>no</u> HOMICIDE <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>✓</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR? <u>✓</u>		

22. I hereby certify that I attended the deceased from Jan 1 -, 1951, to May 28, 1951, that I last saw the deceased alive on May 26, 1951, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

131 W. WASHINGTON ST.,

DATE SIGNED

Dr. Victor D. Miller131 W. WASHINGTON ST.HAGERSTOWN, MD.5/28-1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-29-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>
DATE REC'D BY LOCAL REGISTRY <u>May 29, 1951</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown Md.</u>	

684439

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr Miller

05270

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTRY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
TOWN Hagerstown		TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1621 W. Ave.		STREET ADDRESS 1621 Va. Ave. (If rural, give location)	
3. NAME OF DECEASED (First) Laura (Middle) Edna (Last) Spigler		4. DATE OF DEATH (Month) May (Day) 1, (Year) 1951	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH Aug. 27, 1885	
9. AGE last birthday 65 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Spigler		14. MOTHER'S MAIDEN NAME Clara Randall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	
17. INFORMANT AND ADDRESS Mrs Mary Weller		1625 Va. Ave. Hagerstown, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Nephritis -

Antecedent cause(s)

(b) Diabetes Mellitus

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Arterio-sclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

De-compensation of Heart.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan 1, 1951, to May 1, 1951, that I last saw the deceased alive on 4-30, 1951, and that death occurred at 1-2 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF May 3, 1951		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) Hagerstown, Md	
DATE REC'D BY LOCAL REG May 2, 1951		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Andrew K. Coffman		ADDRESS Hagerstown, Md	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 4 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>525 Pangborn Blvd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Howard</u> (Middle) <u>Edward</u> (Last) <u>Tubman</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 30, 1905</u>
9. AGE last birthday <u>45</u> yrs. <u>6</u> Months <u>12</u> Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering Draftsman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Samuel E. Tubman</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Bevan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>217-05-8813</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary M. Tubman Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

3 hours

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 11, 1951, to May 12, 1951, that I last saw the deceased alive on May 12, 1951, and that death occurred at 7:58 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05272 303

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Clear Spring		CITY (If outside corporate limits, write RURAL and give nearest town) Clear Spring	
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS S. Martin St		STREET ADDRESS (If rural, give location) S. Martin St	
3. NAME OF DECEASED (Type or Print) (First) Ruth (Middle) Ellen (Last) Weaver		4. DATE OF DEATH (Month) May (Day) 4, (Year) 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Apr. 28-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
13. FATHER'S NAME Joseph Bowers		14. MOTHER'S MAIDEN NAME Mary Mills	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS Ralph E. Weaver (Husband)	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) CORONARY OCCLUSION, ACUTE			1 minute
Antecedent cause(s) (b) Hypertensive Heart Disease			unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) None			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-4-51, 19....., to 5-4-51, 19....., that I last saw the deceased dead on 5-4-51, 19....., and that death occurred at 3:20 P.m., from the causes and on the date stated above.

SIGNATURE *Arthur Robert Cohen* MD ADDRESS Clear Spring, Maryland DATE SIGNED 5-5-51

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE May 7, 1951	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Clear Spring, Md.	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>J. W. Murray</i>	24. FUNERAL DIRECTOR <i>Adrian H. Rowland</i>		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 12 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore Dr Hocklander

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>42 Randolph Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>GLENN</u> (First) <u>EARL</u> (Middle) <u>WHITMAN</u> (Last)		4. DATE OF DEATH <u>May 1 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr 23 1951</u>
9. AGE last birthday <u>9</u> yrs. If under 1 year Months <u>9</u> Days <u>19</u>		10. DATE OF BIRTH <u>Apr 23 1951</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Glenn Whitman</u>		14. MOTHER'S MAIDEN NAME <u>Genevieve Boor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Glenn Whitman Hagerstown Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Suffocation due to Asphyxiation of food

Antecedent cause(s)

(b) Pneumonia(c) giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

1 d 171 wkII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Hagerstown Md</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 1 1951</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4/20, 1951, to 5/1, 1951, that I last saw the deceasedalive on 5/1, 1951, and that death occurred at 2:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-3-51</u>	NAME OF CEMETERY OR CREMATORY <u>Hill Crest Burial Park Cumberland Md</u>	LOCATION (City, town, or county) <u>Hagerstown Md</u>	(State)
DATE REC'D BY LOCAL REG <u>May 1, 1951</u>	REGISTRAR'S SIGNATURE <u>Dr. H. H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

204221/91301

RECEIVED
MAY 3 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05274

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH— COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Williamsport</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>310 North Potomac Street</u>	
3. NAME OF DECEASED (First) <u>Ella</u> (Middle) <u>Hoyt</u> (Last) <u>Williams</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>3-4-1867</u>
9. AGE last birthday <u>84</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Livonia, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A.H. Hoyt</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Kelley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Perry F. Prather, Hagerstown</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

2 days.

Antecedent cause(s)

(b) Hypertensive vascular DiseaseYrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) ArteriosclerosisYrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 13, 1951, to May 16, 1951, that I last saw the deceased alive on May 16, 1951, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION Removal (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Reburial</u>	<u>5-18-1951</u>	<u>Lake View Cemetery</u>	<u>Brockport, N. Y.</u>	

DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>May 17 1951</u>	<u>E. Lee McChoy</u>	<u>C. M. Suter & Sons, Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

720826

RECEIVED
MAY 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

05275

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Life</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>W.M. Railroad</u>		STREET ADDRESS (If rural, give location) <u>546 W. Church st</u>	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>Wilbur</u> (Last) <u>Williams</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>July 11, 1897</u>
9. AGE last birthday <u>53</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank K. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Anna Rodenizer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-7412</u>	
17. INFORMANT <u>Miss Nona C. Williams</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a)

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION NO 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

died suddenly at RR office

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

DEPUTY MEDICAL EXAM.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 14, 1951

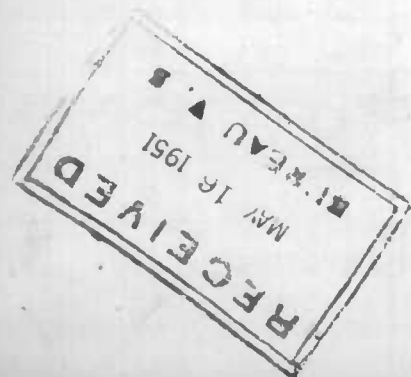
Frank K. Williams

Scott F. Minnich & Son

Hag. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

05276

Reg. Dist. No. 301

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u> TOWN <u>Williamsport Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Iowa</u> COUNTY <u>Webster</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Dodge</u> TOWN <u>Fort Dodge</u> STREET ADDRESS (If rural, give location) <u>Fort Dodge</u>	
3. NAME OF DECEASED (Type or Print) <u>Oscar</u> (First) <u>Fisher</u> (Middle) <u>Wright</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>4</u> (Day) <u>1951</u> (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 1 1871</u>
9. AGE last birthday <u>80 yrs.</u>		10. BIRTHPLACE (State or foreign country) <u>Fort Dodge Iowa</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Paint Salesman</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Wright</u>		14. MOTHER'S MAIDEN NAME <u>Maria Teresa Arnold</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>485-10-9896</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Amos Harper Martinsburg W. Va.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Bacterial Pneumonia</u>			
Antecedent cause(s) (b) <u>Cause not determined</u>			
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2</u> , 19 <u>51</u> , to <u>May 5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>51</u> , and that death occurred at <u>8 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. Williamsport Md</u>	
DATE THEREOF <u>May 7 1951</u>		LOCATION (City, town, or county) <u>Fort Dodge Iowa</u>	
DATE REC'D BY LOCAL REG. <u>May 5-1951</u>		24. FUNERAL DIRECTOR <u>Albert L. Leaf</u> ADDRESS <u>Williamsport Md</u>	
REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

490687

RECEIVED
MAY 8 1951
BUREAU V. S.